**STATE OF TENNESSEE**
**DEPARTMENT OF FINANCE AND ADMINISTRATION**
**DIVISION OF MENTAL RETARDATION SERVICES**
**ANDREW JACKSON BUILDING**
**500 DEADERICK STREET, 15TH FLOOR**
**NASHVILLE, TENNESSEE 37243**

MEMORANDUM

TO: DMRS Regional Directors, Agency Directors, DMRS Regional Training Coordinators, Agency Trainers, DMRS Regional Investigators, DMRS Regional Incident Management Coordinators, Agency Incident Management Coordinators, DMRS Regional Nurse Educators, Therapy Providers

FROM: Stephen H. Norris
Deputy Commissioner

DATE: October 11, 2006

RE: Medication Variance Reporting

The Division of Mental Retardation Services (DMRS) has revised the medication error reporting form entitled Medication Variance MR0484 7-06. The change to the form now reflects if a person administering medications is not certified. This box is located in Section 3 titled, Practitioner/Staff Involved. This item is marked with an asterisk (*) and a footnote is included. A selection in this item will require that a copy of the variance form be submitted to the DMRS Investigator with the Reportable Incident Form. Submission of the Medication Variance report noting the administration of medications by non-certified staff does not automatically warrant an investigation. This will be determined once the information is received and reviewed by the DMRS Investigations unit.

Regional Nurse Educators will send notification of this change to all trainers for this course as well as trainers of the Medication Administration for Unlicensed Personnel course immediately. The revised form (7-06) will be used by trainers as soon as they are notified.

Each agency will be responsible for notifying previously trained staff of this additional requirement and use of the DMRS approved medication variance form in accordance with Provider Manual Chapter 11, 11.8.a. 2). Trending of medication variance concerns should include the category of not certified staff.

Should you have questions please contact the Regional Nurse Educator: East-Joyce Couch, RN (423-798-6255); Middle-Bill Feldhaus, RN (615-231-5432); West-Rosie Key, RN (901-741-7814) or Ruth Givens, DMRS Nurse Education Coordinator (615-532-6547).

SHN/rs

copy: Pat Nichols, DMRS Director of Quality Assurance
John Kaufman, DMRS Director of Compliance
Adadot Hayes MD, DMRS Medical Director
DMRS Nursing Services
Karen Wills, Director of Therapeutic Services
Debbie Payne, DMRS Director of Protection from Harm
Doug Burroughs, DMRS Director of Incident Management
Carol Wilkin, DMRS Director of Investigations
Kim Dean, DMRS Director of Training
Diana Davis, DMRS Compliance Coordinator

# DMRS Medication Variance Report

**Section 1:** Name_____
Age_____
SS /Case #_____

**Section 2:** Time & Location of Variance (circle)
Day of the Week: Su Mo Tu We Th Fr Sa
Date/Time of event_____ ____:____(circle AM/PM)
Location_____
Agency_____
Physician Notified_____Date/Time_____

**Section 3:** Practitioner/Staff Involved

| Classification | Status |
|---|---|
| ( ) Nurse | ( ) Regular |
| ( ) Pharmacist | ( ) Agency/Contract |
| ( ) Physician | ( ) Float |
| ( ) Direct Support Staff | ( ) Other_____ |
| ( ) Respiratory Therapist | ( ) *Not certified (a check here requires investigator notification) |
| ( ) Other_____ | |

Duration of variance _____days_____hours

**Section 4:** Medication and Doses Involved

| Drug ordered and route | Drug given and route |
|---|---|
| _____ | _____ |
| Route: | Route: |
| ( ) IV push | ( ) IV push |
| ( ) IV drip | ( ) IV drip |
| ( ) IM | ( ) IM |
| ( ) SC | ( ) SC |
| ( ) PO | ( ) PO |
| ( ) Per Rectum | ( ) Per Rectum |
| ( ) Per tube | ( ) Per tube |
| ( ) Per trach | ( ) Per trach |
| ( ) Topical | ( ) Topical |
| ( ) Vaginal | ( ) Vaginal |
| ( ) Other_____ | ( ) Other_____ |

**Section 5:** What happened? (Check all that apply)

INCORRECT
( ) Person
( ) Drug
( ) Dose
( ) Route
( ) Formulation
( ) IV Rate
( ) IV Solution
( ) Time
( ) Position
( ) Texture
( ) Dose Omitted
( ) Other_____

( ) Given when criteria (e.g. BP, blood sugar, pain) not met
( ) Extra dose given (e.g. more than scheduled doses or given after stop date or after discontinued)
( ) Given in the presence of documented allergy to drug
( ) Treatment Error

Form of variance: ( ) actual ( ) potential

**Section 6:** Description of Variance: In your opinion why did this variance occur?
Please be specific and refer to the example descriptions below. If necessary, briefly describe event. Variance in:

( ) **PRESCRIBING:** (e.g. incomplete or unclear order, excessive quantity prescribed, wrong drug, etc.)

( ) **TRANSCRIBING:** (e.g. order entered on wrong person, order content changed during schedule revision, incorrect verbal order, etc.)

( ) **PROCUREMENT & STORAGE:** (e.g. lack of standardized storage locations, lack of safe drug storage and stocking practices, lack of standardization of stock drug concentrations, expired drugs, provider failed to fill prescription, etc.)

( ) **DISPENSING:** (e.g. medication mislabeled, wrong medication stocked in satellite pharmacy, wrong medication withdrawn from satellite pharmacy, inaccurate dose calculation, etc)

( ) **ADMINISTERING:** (e.g. medication label misread or not read, previous dose given but not charted or charted incorrectly, person identification not verified, person not available on unit, etc)

( ) **MONITORING:** (e.g. inaccurate documentation of person's weight, necessary tests or procedures not ordered, test procedure results misinterpreted, test procedure results not charted or charted incorrectly, lapse in profile or new order review, etc.)

**Section 7:** Contributing Factors: In your opinion, were there factors that made this variance difficult to prevent or detect?

( ) **PRODUCT** (e.g., unclear manufacturing labeling, "sound-alike" drug names, look-alike packaging, omission or misuse of a prefix or suffix such as "fos" phenytoin or diltiazem "CD" etc.)
( ) **MEDICATION USE SYSTEM** (e.g. side-by-side storage of look-alike drugs, lack of standardization in practice, competing distractions, etc.)
( ) **COMMUNICATION DYNAMICS** (e.g. lack of clear, accurate, and timely written and oral communications related to drug regimen, lack of interactions that are free of fear of intimidation, punishment, and embarrassment etc.)
( ) **OTHER**_____Explain:_____

**Section 8:** Severity of the variance (check one) Use your best judgment, to rate the severity of the variance.

| | |
|---|---|
| **Classification I** | ( ) Category A: Circumstances or events that have the capacity to cause a medication-use variance |
| **Classification II** | ( ) Category B: Variance occurred, but was detected before it reached the individual |
| **Classification II** | ( ) Category C: Variance occurred, reached the individual, but caused no harm or is unlikely to cause harm |
| **Classification II** | ( ) Category D: Variance will require additional person monitoring, but is unlikely to result in a change in vital signs or cause harm |
| **Classification III **** | ( ) Category E: Variance requires intervention and caused or is likely to cause the person temporary harm |
| **Classification III **** | ( ) Category F: Variance caused or is likely to cause temporary harm requiring hospitalization |
| **Classification III **** | ( ) Category G: Variance caused or is likely to cause permanent harm to the person |
| **Classification III **** | ( ) Category H: Variance resulted in a near death event (e.g. anaphylaxis, cardiac arrest) |
| **Classification IV **** | ( ) Category I: Variance resulted in or contributed to the person's death |

***NOTE:*** ***** A selection in this classification and category requires the completion of a Reportable Incident form. (In addition to this form)***

**Section 9:** Your comments. In your opinion, are there improvements or changes that can be made to help prevent a similar event from occurring again? Intervention (e.g. training, monitoring, correction made to MAR, medication obtained, etc.).

Actions/Outcomes:

Signature / Title of person completing form _____ Date _____ Supervisor / Reviewer _____ Date _____

MR-0484
Revised 7-06

**A copy of the Variance form must be submitted with the Reportable Incident Form**
* A copy of the Variance form must be submitted to the Investigator with the Reportable Incident Form *